GROUP BENEFITS

The Board of Stark County Commissioners Benefits Enrollment Form - $10,000 Basic Life and AD&D

THE HARTFORD

Information About You

Name:	Social Security Number:
Date of Birth:	Date of Hire:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*
- **Step 2:** Please **sign, date and return** this form to Human Resources.

Basic Life and AD&D Insurance

You can purchase Basic Life and AD&D Insurance in the amount(s) of $10,000. This coverage is offered without requiring you to provide evidence of insurability.

☐ I elect to **purchase** $10,000 of Life and AD&D coverage at a monthly cost of $1.20.
☐ I **decline** to purchase Life and AD&D coverage, because I am not insured under The Board of Stark County Commissioners' health plan.

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for Basic Life and Accidental Death insurance issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Name: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life Insurance coverage offered through the Board of Stark County Commissioners.

I understand and agree that if I decline coverage now, but later decide to enroll, I may enroll only during an Annual Enrollment Period designated by the Policyholder.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (my employer) can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

Name: _____

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for Supplemental Life and Accidental Death insurance issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life Insurance coverage offered through the Board of Stark County Commissioners.

I understand and agree that if I decline coverage now, but later decide to enroll, I may enroll only during an Annual Enrollment Period designated by the Policyholder.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (my employer) can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

GROUP BENEFITS

The Board of Stark County Commissioners
Benefits Enrollment Form - Supplemental Life/AD&D

THE HARTFORD

Information About You

Name:	Social Security Number:
Date of Birth:	Date of Hire:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*
- **Step 2:** Please **sign, date and return** this form to Human Resources.

Supplemental Life and AD&D Insurance

You can purchase Supplemental Life and AD&D Insurance in the amount(s) of $10,000, $25,000, $50,000, $75,000, $100,000, $200,000 or $300,000. If you are enrolling within 31 days from when you are first eligible, you may elect up to $100,000, without providing evidence of insurability. If you are currently participating in this coverage, you may increase your current coverage by 1 level at your employer's next annual enrollment period, not to exceed $100,000 without providing evidence of insurability. If you were previously eligible for coverage and opted out, you may elect coverage in the amount of $10,000 at your employer's next annual enrollment period, without providing evidence of insurability.

Monthly Cost for Supplemental Life and AD&D Insurance

Coverage Amount	$10,000	$25,000	$50,000	$75,000	$100,000	$200,000	$300,000
Monthly Cost	$4.05	$10.13	$20.25	$30.38	$40.50	$81.00	$121.50

☐ I elect to **purchase** the total amount of $_____ in Life and AD&D coverage.
☐ I **decline** to purchase Life and AD&D coverage.

Change Beneficiary for: ☐ Basic Life ☐ Supplemental Life ☐ Both Plans

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐☐☐☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer: THE BOARD OF STARK COUNTY COMMISSIONERS		Policy Number: GL-402386

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Not Applicable to an Ohio Plan

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ Date: _____

Not Applicable to an Ohio Plan

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ Date: _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

STARK COUNTY COMMISSIONERS ENROLLMENT FORM, BASIC LIFE

Form Used Prior to 1/1/2013

FORMSYSTEMS, INC. CANTON, OHIO 44701 249222

GIP-1

ACCEPTANCE AND PAYROLL DEDUCTION AUTHORITY

DEPARTMENT	SOCIAL SECURITY NUMBER	C
EMPLOYEE'S NAME (PRINT — LAST NAME, FIRST (GIVEN) NAME, MIDDLE INITIAL	DATE OF EMPLOYMENT	H
ADDRESS — NUMBER STREET	DATE OF BIRTH	L
CITY STATE ZIP	SEX (X) ☐ MALE ☐ FEMALE	

BENEFICIARY'S NAME, WITH RIGHT TO CHANGE AS STATED IN THE POLICY. (BENEFICIARY SHOULD BE WRITTEN "HELEN JONES", NOT "MRS. HENRY A. JONES" NOR "MRS. H. A. JONES".)

BENEFICIARY'S NAME (PRINT)

RELATIONSHIP TO EMPLOYEE

IF MORE THAN ONE BENEFICIARY IS NAMED, THE DEATH BENEFIT, UNLESS OTHERWISE PROVIDED HEREIN, WILL BE PAID IN EQUAL SHARES TO THE DESIGNATED BENEFICIARIES WHO SURVIVE THE EMPLOYEE: IF NO SUCH BENEFICIARIES SURVIVES, PAYMENT WILL BE MADE IN ACCORDANCE WITH THE TERMS OF THE POLICY.

INFORMATION REGARDING DEPENDENTS

DO YOU NOW HAVE ELIGIBLE DEPENDENTS? ☐ YES ☐ NO
IF YES, ARE THEY TO BE INCLUDED IN THIS PLAN? ☐YES ☐NO
(IF YES, PLEASE LIST YOUR DEPENDENTS BELOW)

FIRST NAME	DATE OF BIRTH MO. DAY YR.	RELATIONSHIP
		☐ SPOUSE
		☐ CHILD
		☐ CHILD
		☐ CHILD
		☐ CHILD
		☐ CHILD
		☐ CHILD
		☐ CHILD

I HEREBY ACCEPT THE FORM(S) OF GROUP INSURANCE PRESENTLY CONTRACTED FOR BY MY EMPLOYER IN THE STARK COUNTY GROUP INSURANCE PLAN IN THE AMOUNT(S) FOR WHICH I AM OR MAY BECOME ELIGIBLE AND AUTHORIZE UNTIL REVOKED BY ME IN WRITING THE DEDUCTION BY MY EMPLOYER FROM MY EARNINGS OF AMOUNTS SUFFICIENT TO COVER MY CONTRIBUTIONS TOWARD THE PREMIUM UNDER THE SAID GROUP INSURANCE CONTRACT(S).

DATE CARD IS SIGNED SIGNATURE OF EMPLOYEE

EFFECTIVE DATE

Do Not Write Below This Line

Trans.	Special Date	Effective Date	SID	Cross Ref SID	Misc Info	M.C.	Stu

Form Used Prior to 1/1/2013

Stark County Commissioners

SUPPLEMENTAL LIFE and AD&D INSURANCE ENROLLMENT FORM

STANDARD INSURANCE COMPANY

Employee Name: _____ Sex: _____

Date of Birth: _____ Social Security Number: _____/_____/_____

Employees may purchase a benefit amount of: $10,000, $25,000, $50,000, $75,000, $100,000, $200,000, or $300,000. For amounts in excess of $100,000 satisfactory Evidence of Insurability is required. Please complete the Evidence of Insurability form along with this form and return it to your benefits contact.

If coverage is not elected within 31 days of eligibility, Evidence of Insurability is required.

☐ I understand that **I have been offered and have declined** to purchase Supplemental Life/AD&D Insurance. I understand that in the event I request to purchase such insurance at a later date: (1) I will be required to furnish Evidence of Insurability; (2) Standard Insurance Company will have the right to refuse my request.

_____ _____
(Signature) Decline of Insurance Date

Monthly Cost for Supplemental Life and AD&D Insurance

$10,000	$25,000	$50,000	$75,000	$100,000	$200,000	$300,000
$4.30	$10.75	$21.50	$32.25	$43.00	$86.00	$129.00

☐ **I elect $_____ of Supplemental Life and AD&D Insurance.**

Beneficiary Designation: If two or more primary beneficiaries are named and you do not list benefit percentages, proceeds will be paid in equal shares to the named beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary or beneficiaries. Total percentage for each category cannot exceed 100%.

	First Name	Last Name	Date of Birth	Relationship	Benefit %
Primary					%
Primary					%
Contingent					%
Contingent					%

☐ I hereby **request to be insured** and authorize deduction from my pay check for the necessary premium for my share of the cost of the benefit to which I am entitled under the group policy issued to Stark County Commissioners. Once enrolled, **I understand that any changes, including cancellation of this coverage, can only be made once a year during Open Enrollment.** I also understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work.

I VERIFY THAT INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS ACCURATE AND COMPLETE.

Signature: _____ Date Signed: _____

Form Used Prior to 1/1/2013

STARK COUNTY COMMISSIONERS GROUP INSURANCE PLAN

Change of Beneficiary and/or Name

Life Insurance

Employee's Name (last name first) Social Security No.:

County Department

Change my Beneficiary to: (Example: Mary A. Doe, not Mrs. J. Doe)

First name Middle initial Last name Relationship to me

If above space is not suitable for the designation you desire, leave it blank and use the following space—see instructions on the back.

Change my Name:

From			To		
First name	Middle initial	Last name	First name	Middle initial	Last name

Date: Insured's signature:

GIP-3 Please Type

Instructions for Changing Beneficiary

1. To designate one person insert the name and relationship in the spaces provided. If your beneficiary is not related to you, show relationship as "Friend"
2. If you wish to name your estate, insert "Estate" in the blank space.
3. Show a member of religious order in this manner:
   Mary L. Jones, niece, known in religious life as Sister Mary Agnes
4. It is inadvisable to name a beneficiary who is a permanent resident of a foreign country. If such a person is named, furnish full address.
5. More than one beneficiary — Here are the most common examples:

Two beneficiaries	— John J. Jones, father and Mary R. Jones, mother
Three or more beneficiaries	— James O. Jones, brother; Peter I. Jones, brother; and Martha N. Jones, sister
Unnamed children	— My children, living at my death, from my marriage to Lois P. Jones
One contingent beneficiary	Lois P. Jones, wife, if living; otherwise Herbert I. Jones, son
More than one contingent beneficiary	— Lois P. Jones, wife if living; otherwise Herbert I. Jones, son, Alice B. Jones, daughter and Ann Y. Jones, daughter
Unnamed children as contingent beneficiaries	— Lois P. Jones, wife if living; otherwise my children living at my death from my marriage to said wife

   If one of the above examples fits your wishes, insert your designation in the blank space, using the language of the selected example.
6. If none of the above is suitable, explain in the blank space what is desired, or attach a note.

If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to your estate, unless otherwise provided in the Group Policy.

Form Used Prior to 1/1/2013

Stark County Commissioners Supplemental Life Insurance Beneficiary Change Form

Use this form to change the beneficiary designation(s) on your Supplemental Life Insurance coverage only.

Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to the Employer during your lifetime.

Sign and date the completed form and return it to your Human Resources Department.

MEMBER/EMPLOYEE INFORMATION

Your Name (Last, First, Middle)	Social Security No.		
Your Address	City	State	Zip
Group Name The Board of Stark County Commissioners	Group No. 144272-A		

BENEFICIARY INFORMATION

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe, 60%; Jane Q. Doe, 40%."

Primary–Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent–Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature of Member/Employee

Date